Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: NORTHSIDE PAIN RELIEF CENTER 3033 FANNIN STREET HOUSTON, TX 77004	MFDR Tracking #: M4-10-3008-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: NEW HAMPSHIRE INSURANCE CO Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting your assistance in processing the medical bills related to the above-mentioned patient for DOS **03/02/09 and 03/03/09.** Payment was denied for the following reasons: DOS 03/02/09: 18-Duplicate Claim. No initial denial was received. DOS 03/03/09: 45-charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. B5-Coverage/program guidelines were not met or were exceeded. The bills were submitted in a timely fashion along with the pre-authorization letter. The following documents are included in this packet:

Original bills
- Pre-Authorization
- Request for Reconsideration
- EOBs"
-

Amount in Dispute: $321.54

PART III: RESPONDENT'S POSITION SUMMARY

The Respondent did not respond to this dispute.

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
3/2/09	97110	N/A	$73.60	$0.00
3/2/09	97035	N/A	$15.16	$0.00
3/2/09	97140	N/A	$33.85	$0.00
3/2/09	97530	N/A	$38.46	$0.00
3/3/09	97110	N/A	$73.60	$0.00
3/3/09	97035	N/A	$15.16	$0.00
3/3/09	97140	N/A	$33.85	$0.00
3/3/09	97530	N/A	$38.46	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

*The requestor listed the total amount in dispute on the DWC-60 table as $321.54. The actual amount is $322.14.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 2/9/2010 for date of service 3/3/09.

- 18 – Duplicate claim/service.

Explanation of benefits dated 2/11/2010 for date of service 3/2/09.

- 45 – ** There is no second page of the EOB submitted to explain the denial reason code.
- 97 – ** There is no second page of the EOB submitted to explain the denial reason code.
- B5 - ** There is no second page of the EOB submitted to explain the denial reason code.
-

Issues

1. Did the requestor submit the medical fee dispute in accordance with rule §133.307?
2. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to rule §133.307(c)(1)(A) Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. The requestor submitted disputed date of service 3/2/2009. The division received the requestor's dispute on 3/3/2010. Therefore, the 3/2/2009 date of service was not timely filed. Pursuant to rule §133.307(c)(2)(B) The provider shall complete the required sections of the request in the form and manner prescribed by the Division. The request shall include: a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee d ispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB. The provider also submitted disputed date of service 3/3/2009. The Requestor submitted an EOB dated 2/11/2010 for this date of service which supports denial reason "duplicate claim". The requestor did not submit the original EOB for this date of service. The division is unable to determine what the original denial reason is for this date of service. Therefore, reimbursement to the requestor is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

	Susan Weber Grist, CPC	1/25/11
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.